I. PURPOSE

To outline individuals who are authorized to provide care as an Allied Health Provider as well as describe which categories of individuals who will be processed under the Hospital Non-Employee Compliance Policy or Medical Staff Services Department (MSSD).

II. POLICY

Stanford Health Care (SHC), Lucile Packard Children's Hospital Stanford (LPCHS) and Stanford Health Care Tri-Valley (SHC-TV) allow Allied Health Practitioners (AHP) to provide patient care services as permitted by law and accreditation regulations, and in keeping with all applicable rules, policies and procedures of the institutions. An appropriate authorization process is followed to ensure that any individual providing patient care has the required education, training, licensure/certification and competency requirements.

Questions about the implementation of this policy should be addressed to one's supervisor. Further questions can be addressed to Medical Staff Services.

III. DEFINITIONS

A. Allied Health Practitioners (AHP)

AHPs are defined as health care personnel, who are not eligible for medical staff membership, and who are qualified to provide clinical services to patients.

There are two categories of AHP:

1. **Advanced Practice Provider (APP)**
   Advance Practice Provider are advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, CRNA – certified registered nurse anesthetist), a PA – physician assistant or Optometry Doctor (OD). CNS – Clinical Nurse Specialist (who provides direct patient care in a provider role), and other advanced practice categories requiring a supervising physician as identified and as approved by the Governing Body. These individuals are credentialed and privileged through the Medical Staff structure and are required to have a practice protocol evaluated by the Interdisciplinary Practice Committee (IDPC).

These groups of professionals are required to work collaboratively with a supervising Medical Staff member as required by California State Law.

2. Clinical Specialist (CS)

Clinical Specialists are individuals who have been authorized to provide clinical care or service and are generally employees of the hospital or School of Medicine. These individuals include, but are not limited to the following categories:

1. Audiologist*
2. Clinical Nurse Specialist
3. Acupuncturist*
4. Behavioral Therapist*
5. Perfusionists
6. Speech Pathologist
7. Surgical Tech
8. Physical Therapist*
9. PhD Medical Geneticist
10. Massage Therapist
11. Registered Dental Assistant
12. Marriage Family Counselor
13. Registered Nurse First Assistant (RNFA)
14. Genetic Counselors
15. Chiropractors*
16. Any other category identified by the Hospital Board

*Clinical Specialists (CS) who bill for individual services through health plans will also be credentialed by the Medical Staff Services Department. Additionally, their applications will be reviewed by the IDPC Committee. They are noted above with an (*).

If an individual in the above category is a non-employee, reference "Hospital Non-Employee Compliance Policy" through Human Resources Policy Manual.

IV. AUTHORIZATION

1. Individuals applying for status as an Advanced Practice Provider must complete the full credentialing and privileging process and receive appropriate Medical

Staff approval and are not entitled to provide services at either SHC, LPCH or SHC TV until the credentialing/privileging process is completed through Medical Staff Services, Credentials and Privileging Committee and/or the Interdisciplinary Practice Committee (IDPC), Medical Executive Committee and Board Subcommittee.

2. Requests to add new AHP categories, or to modify existing job categories, job descriptions, privileges or protocols, must be submitted in writing to IDPC Committee. Any relevant documentation needed to review and recommend category additions or deletions will be requested. All requests must be approved by the Interdisciplinary Practice Committee, Medical Executive Committee, and Board of Directors.

   For new categories, the protocol/job description, privileges must be approved through the Board of Directors before a provider can apply to the position.

V. PROCEDURE

A. Pathways for Credentialing

1. To be eligible to provide services, an Advanced Practice Provider must:

   a. have written approval, both on the application form and on applicable practice protocols, job descriptions and/or privileges, from the clinical service chief or department chair and/or the appropriate administrative department to provide services under the supervision of an active medical staff member as an AHP.

   b. complete the credentialing and privileging process and be approved through the appropriate committee structure.

2. All categories of APP must meet hospital HIPAA requirements and complete any training modules required for hospital clinical systems.

3. All Advanced Practice Provider will be reappointed to the AHP staff, through Medical Staff Services, every two years

B. Scope of Services Oversight

1. The Interdisciplinary Practice Committee (IDPC) of each facility oversees the development, review and approval of authorization criteria, scope of services, practice protocols and other relevant specifications of the following types of providers, in accordance with Title 22:

    a. Nurse Practitioners
    b. Physician Assistants
    c. Clinical Nurse Specialists, as appropriate
    d. Certified Nurse Midwives
    e. Certified Registered Nurse Anesthetists
    f. Other providers whose practice patterns overlap the medical scope of practice.
    g. Other providers as identified by the Board of Directors

2. The Interdisciplinary Practice Committee, or the sponsoring department, has the responsibility of establishing a framework for the categories they oversee. This framework shall include at least the following:

    a. Category description, including title and general description of category.
    b. Training and qualifications, including specific guidelines regarding certification, licensure, experience, continuing education requirements, etc.
    c. Scope of services, which identifies the patient populations to be served and the specific procedures to be performed by the AHP.
    d. Level of supervision of the AHP. Documentation should specify how the AHP is supervised when performing services, provide evidence of appropriate supervisor licensure as required and identify authority for documentation/medical record signature.
    e. Standardized procedures or protocols as appropriate, including standardized procedures for the assessment and management of patients, standardized procedures for dispensing and furnishing of drugs, etc.
    f. Specific rules, regulations and/or policies that apply to the category of AHP.

g. Special requirements which must be met prior to provision of any services, which may include department-specific orientation, health screening, Basic Life Support (BLS) certification, etc.

h. Requirements for completion of probationary period or competency assessment for all AHPs.

i. Method for evaluating competency to perform scope of services (which must identify proctoring or precepting requirements).

j. Physician or Supervisor responsible for monitoring and documenting the provider's performance.

k. Review timeframes and any related materials such as monitoring forms or skills checklists.

l. At all times the supervising physician must be physically, telephonically or electronically available to the APP for consultation, except in emergency situations.

m. In cases of emergency, the APP, to the extent permitted by the laws relating to license or certificate, may render emergency services to a patient pending establishment of contact with physician.

n. PAs may perform medical services set forth by the regulations of the MBC when the services are rendered under the appropriate supervision of a licensed physician. [16 CCR § 1399.545(a); CA Business & Professions Code § 3516]

o. Process to ensure that required supervision is being conducted on all allied health professionals , (e.g., NPs, PAs), in all pertinent areas of care.

p. The supervising physician has continuing responsibility for all medical services provided by the health professional under his or her supervision. [16 CCR § 1399.545(f); CA Business & Professions Code § 3502] In the clinical setting, the supervising physician must not supervise more than 4 APPs involved in direct patient care at one time.

3. These documents must be forwarded to Interdisciplinary Practice Committee (IDPC) and/or the Credentials and Privileging Committee and the Medical Executive Committee of the appropriate institution for review and recommendation for approval to the SHC, LPCH and SHC TV Boards of Directors.

C. Verification Responsibilities

1. Medical Staff Services maintains credentialing files on Advance Practice Providers. All other AHP files are maintained by Human Resources if the AHP is an employee or the respective Department if the AHP is a non-employee.

2. Advance Practice Providers

   a. Medical Staff Services, through its normal verification process as outlined in Credentialing and Privileging Policy and Procedures, confirms that each Advance Practice Provider applicant meets the established qualifications and requirements as defined in the Credentialing Policy and Procedures.
   b. Medical Staff Services also ensures that Advance Practice Provider applicants are informed of the following:

      1) Professional Ethics
      The professional conduct of each APP shall be governed both by the principles of professional ethics established by the profession, by law, and in accordance with the mission and philosophy of SHC, LPCH and SHC TV.
      2) Suspension, Modification, or Termination of Permission to Provide Services
      APPs may be subject to discipline and corrective action, and his or her permission to provide services may be suspended, modified, or terminated as delineated in Section E of this document.
      3) Requirement for background check.

3. <u>Clinical Specialists</u>

   a. The designated department manager maintains a personnel file for each Clinical Specialist. This file includes a Job Description, Performance Appraisals, and other documentation as required by SHC, LPCH and SHC TV Human Resources policies and procedures, including licensure and certification (see Hospital Non-Employee Compliance Policy).

b. The respective department manager performs the appropriate verifications based on Human Resource Policies and Regulatory Guidelines(see Hospital Non-Employee Compliance Policy).

D. Billing

As allowed by California law, and SHC, LPCH and SHC TV policies, certain categories of AHP are eligible to bill for their services. These providers must be authorized to provide services as defined in this policy prior to any billing activity.

E. Procedural Rights for Advance Practice Providers (APPs)

1. <u>Non-renewal, Restriction, Suspension, or Termination</u>

a. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP to the procedural rights set forth in Article Seven of the Bylaws. Any APP, however, shall have the right to challenge any action that would constitute grounds for a hearing under Article Seven of the Bylaws by filing a written grievance with the IDPC within fifteen (15) days of such action. The grievance shall set forth the specifics of the action or inaction challenged and shall detail the remedy requested. On receipt of such a grievance, the IDPC or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as that term is defined in Article Seven of the Bylaws and the procedural rules applicable to such hearings shall not apply. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The IDPC shall make a decision based on the interview and all other information available to it.

After the IDPC makes a final recommendation to the Medical Executive Committee, the APP may then request reconsideration

by the Medical Executive Committee of an adverse IDPC recommendation. In that reconsideration, the APP may present to the Medical Executive Committee additional written arguments relevant to the IDPC recommendation. There is no right for the APP to personally appear before the Medical Executive Committee. After considering the AHP's additional written arguments, if any, the Medical Executive Committee shall make a final decision on the IDPC's recommendation. The final decision will be made by the Board of Directors via the Board Subcommittee.

2. <u>Automatic Termination</u>

An APP practice privileges shall automatically terminate, without review, in the event:

a. The Medical Staff membership of the Supervising Physician of the APP is suspended, terminated, or restricted whether voluntarily or involuntarily. An employed APP may be assigned a different supervising physician by the Service Chief.
b. Any contract between the Hospital and the Supervising Physician of the APP is terminated, regardless of the reason therefore; the APP's Supervising Physician no longer agrees to act as a supervisor, for any reason, or the relationship between the APP and the Supervising Physician is otherwise terminated, regardless of the reason. An employed APP will be assigned a different supervising physician by the Service Chief.
c. The APPs license or certificate to practice expires, is revoked, suspended, or otherwise restricted.

3. <u>Other Corrective Action</u>

a. When the APPs DEA Certificate is revoked, suspended, or subject to probation, the action and terms shall automatically apply to his/her right to furnish or transmit orders for medications covered by the certificate.

b. For failure to comply with the Medical Record Regulations and

Policies established by the Medical Staff Rules and Regulations or hospital-specific policies and procedures, the APP's practice privileges shall be automatically suspended upon the expiration of five (5) days after he/she is given written notice. Practice privileges shall remain suspended until all delinquent medical records are completed. A failure to complete the medical records within two (2) months after the date a suspension becomes effective shall be deemed a voluntary resignation.

c. For failure to maintain the appropriate amount of professional liability insurance or its equivalent, if any, an APP's practice privileges may be automatically suspended after ten (10) days written warning of delinquency. Privileges shall remain suspended until the APP provides evidence to the Medical Executive Committee that he/she has secured professional liability coverage in the amount required. A failure to provide such evidence within three (3) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation. APP's on leave of absence are not subject to automatic suspension for failure to provide evidence of professional liability insurance.

3. Review of Category Decision
The procedural rights afforded by this section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges at the Hospital. Questions regarding such decisions shall be submitted to the Governing Body, which has the discretion to decline to review the request, or to review it using any procedure it deems appropriate.

4. Provider Rights to Amend Application
If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked to resolve this discrepancy.

5. Confidentiality of files
APP Credentialing files are treated as confidential and are protected from discovery by Section 1157 of the California Evidence Code. Documents in these files may not be reproduced or distributed, except for confidential peer review and authorization purposes consistent with Section 1157.

VI. RELATED DOCUMENTS

Human Resources Policy: Hospital Non-Employee Compliance Policy

VII. <u>DOCUMENT INFORMATION</u>

A. References:

The Joint Commission Standards for Human Resources and Medical Staff
HR 01.02.05 and HR. 01.02.06
Human Resources Policy: Hospital Non-Employee Compliance Policy

B. Author/Original/Review Date:
Director, Medical Staff Services, February 2009, April 2011
Director, Practice Professional Practice February 2009
Manager, Human Resource Compliance, April 2011

C. Custodian of Document:
Medical Staff Services, Human Resources and Interdisciplinary Practice Committee (IDPC)

D. Distribution and Training Requirements:
1. This policy resides in *Administrative Manua1 and Medical Staff Policies* located on the SHC and the LPCH websites.
2. New or revised documents will be communicated as appropriate.

E. Review and Renewal Requirements:
This policy will be reviewed every three years and as required by change of law or practice. The entities or persons who provided initial approval must approve any changes to the policy.

F. Review/Revision History:
3/01, 1/04, 10/05, 12/07, 1/09, 10/09, 4/11, 5/14, 12/16, 5/19, 8/19, 3/22

G. Approvals:
SHC Interdisciplinary Practice Committee, 4/11, 5/14, 5/19
LPCH Interdisciplinary Practice Committee, 3/09, 4/11, 5/14,5/19, 3/22
LPCH Policy Committee, 4/11, 6/14, 12/16, 5/19, 8/19
SHC-TV Interdisciplinary Practice Committee - 03/22

H. Board Approvals:
SHC Medical Executive Committee – 2/04, 2/08, 11/09, 5/11, 6/14, 1/17, 5/19, 9/19, 4/22, 7/22

LPCH Medical MEC – 2/04, 11/05, 2/08, 4/01, 4/11, 6/14, 12/16,5/19, 4/22
SHC-TV - 3/22

SHC Board of Directors – 2/04, 2/08, 11/09, 5/11, 6/14, 1/17, 5/19, 4/22, 7/22
LPCH Board of Directors – 2/04, 11/05, 2/08, 4/10, 5/11, 6/14, 12/16, 5/19, 9/19, 4/22
Administrative Clarifications – 10/12
SHC-TV – 4/22, 6/23